Client Name ____
Date of Birth____
Skin Care Therapist________________________ Date __________

Personal History Questionnaire

What skin conditions would you like to improve? ____

____

What expectations do you have from your facial treatment? ________________________________

____

What do you enjoy the most from a facial treatment?_______________________________________

____

When was your last facial? ______________________________ ______________________

Do you wear contact lenses? .... ❑yes ❑no
Do you follow a special diet? .... ❑yes ❑no
Do you supplement your diet with vitamins? .... ❑yes ❑no
Any food allergies? Iodine? If YES, what medication are you using?________________ ❑yes ❑no
Do you drink 8 glasses of water daily? .... ❑yes ❑no
Do you smoke? If so, how much? .... ❑yes ❑no
Do you have any cosmetic allergies? .... ❑yes ❑no
Are you allergic to latex gloves? .... ❑yes ❑no
Are you experiencing stress or nervous tension? .... ❑yes ❑no
Do you have eczema, psoriasis or dermatitis? .... ❑yes ❑no
Do you have a history of fever blisters? .... ❑yes ❑no
Do you have a history of skin cancer? .... ❑yes ❑no
Are you claustrophobic? .... ❑yes ❑no
Do you use tanning beds? .... ❑yes ❑no
Do you have a pacemaker? .... ❑yes ❑no
Do you participate in vigorous aerobic activity or sports? .... ❑yes ❑no
Are you currently having facial waxing, electrolysis, or using depilatories? .... ❑yes ❑no
Are you considering facial cosmetic surgery? .... ❑yes ❑no
Are you under a dermatologist's care? .... ❑yes ❑no
If YES, what is doctor's name? ____
Do you have a history of blistering sunburns as a child or as an adult? .... ❑yes ❑no
Do you use a sun block of SPF 15 or higher daily? .... ❑yes ❑no
What is your approximate sun exposure time per week? Occupational__________Recreational________
Are you currently taking Accutane or using a Retin A, Renova, Avita, or Differin? .... ❑yes ❑no
If YES, what strength?__________________How frequently?________________________
Are you currently using Glycolic Acid products? .... ❑yes ❑no
If YES, what strength?__________________How frequently?________________________
Please check any health problem, past or present: ❑Diabetes ❑Heart ❑Hepatitis
❑Thyroid ❑Cancer ❑Hormonal Problem ❑Acne ❑High Blood Pressure
Current cosmetic skin care program includes: (please include brand names)

Soap/Cleanser: ____
Toner/Astringent: ____
Moisturizer (day/night): ____
Eye Cream/Eye Gel: ____
Surface Peel/Facial Exfoliator:____
Mask: ____

For Women Only:

Are you currently taking hormone replacement therapy? .... ❑yes ❑no
Are you currently taking birth control pills? .... ❑yes ❑no
Are you pregnant? .... ❑yes ❑no
Are you nursing? .... ❑yes ❑no